South East
Local Health Integration Network

Goals, Engagement, First Steps

South East Local Health Integration Network
2006-2007 Annual Report

Ontario

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2006-2007 Annual Report approved by

Georgina Thompson, Chair, Board of Directors

Kenneth A. McBain, Member, Board of Directors

To the South East LHIN:

All Board members of the South East LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy.

Sincerely,

Honourable Sydney L. Robins, Q.C.
Conflict of Interest Commissioner

Standing (left): Paul Huras, John Groves, Kenneth A. McBain, Ian Wilson, Tom Rankin
Seated (left): Gaye McGinn, Florence Campbell, Georgina Thompson, Margaret Werkhoven **Not shown:** Balu Patel

Board of Directors Terms

April 1, 2006 – March 31, 2007

Georgina Thompson, Chair
Belleville
Term 2005-2008

Florence Campbell, Vice-chair
Kingston
Term 2005-2008

John Groves, Member
Brockville
Term 2006-2008

Kenneth A. McBain, Member
Madoc
Term 2006-2008

Gaye McGinn, Member
L'Amable
Term 2006-2007

Balu Patel, Member*
Stirling
Term 2006-2007
(*Resigned 2006)

Thomas Rankin, Member
Merrickville
Term 2006-2007

Margaret Werkhoven, Member
Prince Edward County
Term 2006-2007

Ian Wilson, Member
Amherstview
(On leave of absence as of February 2007)

Paul Huras, CEO

Message from Georgina Thompson, *Chair of the Board of Directors*

March 31, 2007

To the Communities, Individuals, and Health Service Providers in the South East Local Health Integration Network:

The fiscal year April 1, 2006 to March 31, 2007 was my second as Chair of your South East Local Health Integration Network Board of Directors. This has been a full, exciting, and very rewarding year of learning and growth for the Board in preparation for the day of official hand-off from the Ministry of Health and Long-Term Care.

Your Board was proud that the Ministry's own readiness assessment in Q4 showed that the South East LHIN was in good shape for the transfer of Accountability Agreements. This was proven as on April 1 we assumed our mandated responsibility for funding more than 100 Health Service Providers.

Our first round of service agreements will be done with the hospitals in preparation for the end of their contracts with the Ministry in 2007, when we start to work with them to develop service agreements for 2007-2008.

Community Engagement:

I thank all the communities, health care professionals, health service providers, and individuals across the region who called, spoke, and wrote to us. We welcomed the notices and invitations to attend meetings, conferences, and symposia throughout the year. As Chair I had the pleasure of speaking with many of our counterpart Boards of Directors of hospitals and other Health Service Providers across the region, and I ask all of you to please continue the dialogue and provide feedback.
The conversation that we started in 2005-2006 must continue in this year and beyond, if your South East LHIN Board is to continue to develop into a cohesive, high-functioning, and confident group of community representatives. Your on-going contribution is essential as we work in partnership to roll out the priorities identified in the Integrated Health Services Plan.

A personal highlight for me was an invitation to speak in March on behalf of the Honourable George Smitherman, Minister of Health and Long-Term Care, at a symposium at the Centre for the Study of Democracy, Queen's University. It was remarkable to see that so many of our key opinion leaders from different sectors are embracing the notion that we must identify regional priorities and regional solutions.

Of note, the Board looks forward to holding our meetings around the region in the coming year.

Board Members:

Turning to some specific Board matters, in Q4 we thanked Balu Patel for his diligent and thoughtful service to the Finance Committee and the Integrated Health Service Providers Working Group. With regret, we accepted his resignation. As of June 2007 we await word of his replacement from the Ministry. As well, Board member Ian Wilson is on a six-month leave of absence.

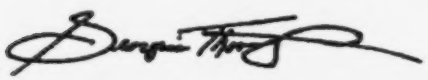
Committees:

In follow-up to the SE LHIN – 2005/06 Annual Report, we are pleased to inform you that we have all committees in place, with their terms of reference: Audit, Finance, Nomination, and Governance.

Collaborative Governance:

An exciting development pertains to our governance role. A subsection of the Governance Committee is our "collaborative governance" team. With the guidance of Board Vice-chair Florence Campbell, this team has its own terms of reference and represents our health care sectors. At present the team is in place for a year and has started a series of meetings throughout the region. These meetings demonstrated a real need, as many representatives stated that they were learning a great deal about the other sectors, proving once again the value of dialogue and sharing. We look forward to hosting our counterpart Board members from many Health Service Providers at workshops scheduled for September.

In closing, on behalf of the Board I would like to thank our CEO, Paul Huras, and his staff for seeing all the opportunities for our organization in this wonderful region. We believe that they are indeed bringing the goals of our Integrated Health Services Plan to life.



Georgina Thompson
Chair, Board of Directors
South East Local Health Integration Network

Message from the Chief Executive Officer

March 31, 2007

To the Communities, Individuals, and Health Service Providers in the South East Local Health Integration Network:

The first full year of the South East Local Health Integration Network (SE LHIN), April 1, 2006 to March 31, 2007 has been filled with promise and achievement. Our Ontario health care system needed to transform, and it is transforming. Our health care providers are championing new approaches to working together to meet both community and patient needs. LHINs have been given the mandate and opportunity to enable these changes and I believe we are achieving success.

Milestones for our new organization included the Government passing Bill 136, the Local Health Integration Act; the SE LHIN signing its first Accountability Agreement with the Minister of Health and Long-Term Care; recruitment of our full complement of 18 staff; and the preparation of the transfer of funding responsibilities for April 1, 2007.

As our infrastructure was being built, the SE LHIN undertook its responsibilities as defined in its mandates. Community Engagement included many visits with local provider groups; establishing relationship with local media; media events to announce new initiatives such as the allocation of new long-term care beds; and presentations and discussions with many local community groups across the region.

An important milestone was the delivery of our first SE LHIN Integrated Health Services Plan (IHSP) to the Minister of Health and our local communities in October 2006. This IHSP identified priorities for improving our local health care system based on the analysis of relevant data and community input from 109 meetings in 22 communities across the South East LHIN. These priorities are now being addressed through specific project plans.

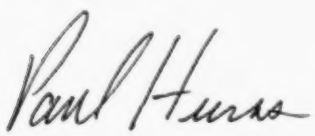
Communities advised us to improve access to care in areas such as primary health care, specialty care, and mental health and addictions services. Through our work with providers, we are starting to see efforts towards results. Although still in early stages, we are moving toward a comprehensive integrated primary health care system; a regional surgical program; enhanced critical care resources; and improved patient flow processes to better place those non-acute care patients who are inappropriately placed in acute-care beds.

With a full complement of staff, we prepared for the funding transition. Together with the Ministry of Health and Long-Term Care we identified the detailed funding roles the LHIN would need to allocate more than $800,000,000 of annual transfer payments to local providers and to set targets and monitor performance. True to expectations, the SE LHIN staff members met the necessary time frames, and are now working with providers to fulfill these functions.

The future for health care in Ontario is exciting, but it requires us to move forward strategically. We are privileged to have $36 billion allocated to health care in this province, which represents 46% of the total provincial budget. That allocation comes with a tremendous amount of responsibility. We must ensure that we maximize the value of our limited precious resources. In the South East LHIN we will try to find regional responses to regional need utilizing regional capacity. By thinking regionally and acting locally in a coordinated way, we will be responsible and confident in meeting all of our community's needs.

As we undertake planning in these priority areas with our health care partners we are already identifying some promising specific projects and initiatives for development. I look forward to reporting on our progress next year. Meanwhile, I thank the Board of Directors and staff team of the SE LHIN for their commitment to improving our health care system. With the exceptional quality of health care providers and the clear expectations of our communities, we are moving forward to an exciting future.

Sincerely,



Paul Huras
Chief Executive Officer
South East Local Health Integration Network

Goals, Engagement, First Steps

In its first full year of operation the South East Local Health Integration Network experienced true metamorphosis. Under the leadership of Chair Georgina Thompson and the Board of Directors, founding CEO Paul Huras and senior directors Sherry Kennedy and Nancy Sears brought the LHIN forward from idea to reality.

Each month in the year April 1, 2006 to March 31, 2007 was one of exponential growth in building infrastructure and capacity, even as the South East LHIN executed the ambitious slate of deliverables as mandated by the Ministry of Health and Long-Term Care. While we expected that the year would be hectic, what we could not anticipate was how far the South East LHIN could come in just twelve months. Consequently, the actual date of transferring the responsibility for the SE LHIN region, April 1 2007, went as well as the senior staff and Board had hoped.

i. Laying the Foundation

Core arenas of activity for senior staff involved laying the foundation in preparation for the South East LHIN assuming these mandated responsibilities.

Building relationships and community engagement:

The task of building external relationships started almost immediately, developed and carried forward by each successive personnel hire.

Ministry of Health and Long-Term Care, and other LHINs:

As a Crown agency, the South East LHIN has invested many days in forging its central relationship with both the Ministry itself and with its thirteen sister LHINs. Consultations extend at each level of the Ministry that is concerned with LHINs, from the Minister, the Deputy Minister, through management and operational staff. At each level, staff also established links with their counterparts at other LHINs for information-sharing, learning, and idea generation. In turn, the Ministry supported these efforts by creating offices such as the LHIN Liaison Branch and a communications support office.

Our Roadmap

The Integrated Health Services Plan includes the LHIN's goals, priorities, and strategies for enhancing health care delivery through better integration of services within the South East LHIN.

Throughout the year the South East LHIN worked closely with the Ministry in building foundational elements and ongoing development work. These include creating and refining process protocols, as well as document and reporting templates, consulting on data resources, training, and diverse communications and media relations activities (that sometimes involved the Minister and the region's Members of Provincial Parliament). It also included the South East LHIN's on-the-ground support of the Ministry in its Wait Times strategy. Meanwhile, the first iteration of a web site, plus some direction for the second iteration, was rolled out in 2006. This development work in support of transition of responsibility for Accountability Agreements is ongoing.

South East LHIN Community and Health Service Providers:

Reflecting the fact that community engagement is a core mandated activity for all LHINs, initiating outreach to and dialogue with the community and health service providers within the South East region was a central focus of activity throughout 2006. While developing the Integrated Health Services Plan, that dialogue began with hundreds of individuals and many dozens of health organizations in the South East region.

In the 109 meetings held in 22 communities as part of the IHSP development process, the receptivity and interest shown by residents

exceeded expectations. The public came to these meetings with questions, ideas, concerns, and suggestions, and most importantly, with all the insight necessary to give the Board of Directors direction in setting priorities for the South East LHIN into 2007 and beyond.

A Good System

Review of data and community feedback shows that for the most part, the health care system in the South East LHIN is working well. The South East LHIN's task is to take a good system and make it better.

Another important mandated vehicle for community engagement is the fact that the Board's meetings are open to the public as observers. Guest observers, including Health Service Providers, have attended many meetings.

As anticipated, a few specific groups entered discussion with the South East LHIN with anxiety or even antagonism. The South East LHIN views the opening of dialogue as a positive.

In preparation for the actual transfer of the Accountability Agreements on April 1, 2007, the South East LHIN held four introductory informational sessions across the region, which were open to all HSPs. Attendees supported this initiative, and the interchange was open and positive.

At the same time, the South East LHIN welcomed specific assistance from some Health Service Providers. In particular, the Community Care Access Centre of the South East region, as well as hospitals and community support centres, were generous in sharing venues and the like. As intensive as the IHSP community-meeting process was throughout Q1 and Q2, staff and Board members have also attended dozens of community meetings, either as invited speakers, guests, or observers. The fact that in Q4, Queen's University invited both the CEO and Board Chair as keynote speakers at a symposium on hospital utilization indicates some good relationship-building in this sector, as well as among Health Service Providers.

An important mandated step in community engagement for the year 2006-2007 was the SE LHIN's initial outreach to the Tyendinaga Mohawk Territory and subsequent meeting with Chief R. Donald Maracle. The South East LHIN hopes that further dialogue will follow.

Also important, staff connected with existing networks among many professional, interest, and consumer groups throughout the South East region. The Board Chair and CEO, as official spokespersons, accepted many invitations to speak to professional and community groups.

All of this public activity moves forward while we continue to have meetings with individual Health Service Providers. Similarly, as awareness of the SE LHIN has increased, individual residents have queried the SE LHIN on a broad range of topics.

Building the road map – Integrated Health Services Plan:

As directed by the Ministry, creating the Integrated Health Services Plan (published October 2006) in Q1 and Q2 was the main process and vehicle for laying out the South East LHIN's priorities.

A large piece of work that consumed six months of effort, its value as a road map was demonstrated before the end of Q4. The themes, priorities, and activities described in the IHSP are a sturdy, wide-ranging, and realistic framework for activity for the next two years at least, while laying the necessary foundation for a data research platform and an eventual strategic business plan.

Population Health

Important aspects of the SE LHIN's demographic profile include:

- *Low population density*
- *Older population compared to other LHINs*
- *Significant burden of illness and chronic disease associated with aging*
- *Highest reported prevalence of arthritis/rheumatism among LHINs*
- *Life expectancy at birth is in lowest quartile in province*

Utilization of Services

- *Highest rate of Emergency Department visits of southern Ontario LHINs*
- *Residents reported difficulties in accessing primary health care and specialty care*
- *Use of tertiary/quaternary inpatient hospital care is second highest in province*
- *Rate of alternative level of care days is highest among the 12 southern LHINs*
- *Residents and health care professionals note a lack of supportive housing dedicated to elderly residents*

Data from the IHSP

This document integrates directives, needs, and sensitivities from the Ministry, the Board, Health Service Providers, and the community at large. An additional benefit of the process itself was that it sparked internal discussions about renewal, networking, and integration among some Health Service Providers. In at least one instance, an HSP's own decision-making and planning showed that it was on the path of enhancing service provision while eliminating redundancy. In this respect the South East LHIN proved itself a catalyst for positive change, even at this early stage.

By March 31, financial, research, and integration staff at the South East LHIN had identified some limitations in the initial roll-out of technology and information technology infrastructure. This sets some direction for 2007 as working with other LHINs and the Ministry to fill gaps and expand capacity is an important stream of activity for 2007-2008.

Building human capacity: Senior staff completed hiring of a total of eighteen staff. (One senior consultant is set to come on board in Q1 2007). The South East LHIN attracted many expert applicants from within the South East region as well as elsewhere in Ontario. This resulted in a staff mix that has a depth of experience in the South East as well as a breadth of experience across sectors and organizations in Canada and internationally. These new employees have experience in, for instance, Ministry of Health and Long-Term Care (and its Regional Office and Management Board), District Health Councils, Community Care Access Centre, hospitals, the Canadian Armed Forces, the federal government, nonprofit health associations, health publishing and public affairs, and other relevant sectors including telecommunications and high-tech. Among staff are three health care professionals.

It is important to note that the South East Board and senior staff determined early on that the best health planning requires good information and data. For that reason we placed importance on developing a flexible, sensitive, and powerful data and performance-measurement capacity. Consequently the South East LHIN took care to hire an expert data and performance team to create the tools upon which the integration expertise will rely.

We also note the contributions of expert counsel and support from contract and allied ministry staff as well as, for example, Paul McAuley, the LHIN's consultant in e-health, and contract suppliers who assisted with the IHSP process and document.

ii. Priorities for Change

Based on the community input and on feedback from Health Service Providers during development of the Integrated Health Services Plan, the Board approved the following priorities.

Enhanced access to:

- Primary health care services
- Specialty health care services
- Mental health services
- Addiction services
- Rehabilitation services
- Long-term care services
- Transportation to and from care

In addition, the Ministry's directives included:

- Integration of services along the continuum of care
- Engagement with Aboriginal communities
- Ensuring French language access
- Integration of e-health
- Development of a regional health human resources plan

iii. First Steps

The task of developing work plans and activities to bring forward the priorities for change started throughout Q3 and Q4. As noted, some Health Service Providers made their own strides in adapting the South East LHIN goals to their own processes and planning, demonstrating the LHIN's additional value as a catalyst.

The following are some examples of deliverables and projects that started in the Q3 and Q4. The South East LHIN Board and staff are excited about projects such as:

- Primary Health Care forum (planned for Q3 2007)
  - The South East LHIN is hosting its first regional forum to bring together key players in primary health care
- Regional patient registry
  - The SE LHIN started early-phase consultation on a patient registry of individuals who are seeking a primary health care physician or team; the idea holds promise as a more efficient and effective tool than existing physician registries
- Wait times software development in partnership with local expertise at Queen's University
  - The South East LHIN began reviewing existing and potential software tools to address the province's wait time strategy in this region
- Emergency Department Action Plan for improved patient flow
  - The South East LHIN received part of a $1.3 million dedicated fund from the Province in 2006, which is targeted to enhancing patient flow from the Emergency Departments at Kingston General Hospital and Quinte Health Care Corporation

cont'd...

cont'd...

- The South East LHIN is facilitating a realignment of resources that will see community support workers placed within the Emergency Departments themselves

- In 2006, community health centres in the South East LHIN started work on primary health care satellites for Napanee and Quinte West
- In the area of mental health and addictions, the South East LHIN supported and worked with community partners on a centralized intake process for mental health services, streamlining wait lists and bringing more clarity to patients and health care professionals
- Lennox County and Addington County mental health services independently amalgamated
- Early discussion with health care professionals in the region supported recruitment and planning of family health teams and networks
- In 2006, the Board considered how it might offer leadership for integration through its own relationships with its counterparts at Health Service Providers
  - Planning is underway for a Collaborative Governance symposium in Q2 2007
- In Q4, the South East LHIN began working with the Ministry on roll-out of an enhanced web site and community engagement tool that includes interactive features
  - The goal is for this tool to be the hub of the LHIN's communications and outreach activities
- In Q4, the data set team began identifying and seeking access to data resources that will enhance the South East LHIN's ability to understand utilization on the one hand, and plan on the other

The South East LHIN Board and staff believes that these selected deliverables demonstrate our ability to transition from research, to planning, to implementation. We look forward to implementing these and other initiatives throughout 2007 and beyond.

Most of all, we look forward to continuing the discussions that were started in 2006 throughout the region. Engaging the intelligence, creativity, commitment, and expertise of individuals and organizations alike remains the highest priority in delivering on the promise of improved health care and better population health.

Deloitte

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Auditors' Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the statement of financial position of South East Local Health Integration Network (the "LHIN") as at March 31, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of South East Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
April 27, 2007

Member of
Deloitte Touche Tohmatsu

South East Local Health Integration Network

Financial Statements

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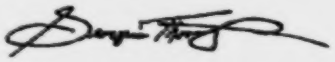
South East Local Health Integration Network

Statement of Financial Position

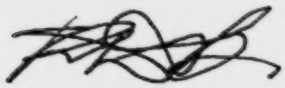
March 31, 2007

	2007	2006 (Notes 3, 14)
FINANCIAL ASSETS		
Cash	**$ 1,027,427**	$ 28,370
Accounts receivable	**4,931**	-
	1,032,358	28,370
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	**576,671**	-
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**438,410**	28,370
Due to MOHLTC - E-Health (Note 5)	**25,218**	-
Due to the LHIN Shared Services Office (Note 6)	**53,241**	-
Deferred capital contributions (Note 7)	**165,994**	43,552
	1,259,534	71,922
NET DEBT	**(227,176)**	(43,552)
NON-FINANCIAL ASSETS		
Prepaid expenses	**61,182**	-
Capital assets (Note 8)	**165,994**	43,552
	227,176	43,552
ACCUMULATED SURPLUS	**$ -**	$ -

APPROVED BY THE BOARD OF DIRECTORS



Director, G. Thompson, Chair of the Board



Director, K. McBain, Chair, Audit Committee

Statement of Financial Activities
March 31, 2007

	2007 Budget (unaudited) (Note 9)	2007 Actual	2006 Actual (Notes 3, 14)
REVENUE			
MOHLTC funding	**$ 3,402,406**	**$ 3,166,435**	$ 241,961
E-Health funding (Note 5)	**-**	**104,000**	-
Other revenues	**-**	**548**	-
Amortization of deferred capital contributions (Note 7)	**-**	**56,961**	14,804
	3,402,406	**3,327,944**	256,765
EXPENSES			
General and administrative (Note 10)	**3,402,406**	**2,785,534**	228,395
E-Health (Note 5)	**-**	**78,782**	-
	3,402,406	**2,864,316**	228,395
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	**-**	**463,628**	28,370
FUNDING REPAYABLE TO THE MOHLTC	**-**	**(463,628)**	(28,370)
OPENING ACCUMULATED SURPLUS	**-**	**-**	-
CLOSING ACCUMULATED SURPLUS	**$ -**	**$ -**	$ -

Statement of Changes in Net Debt
March 31, 2007

	2007	2006 (Notes 3, 14)
ANNUAL SURPLUS	**$ -**	$ -
ACQUISITION OF TANGIBLE CAPITAL ASSETS	**(179,403)**	(58,356)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	**56,961**	14,804
CHANGE IN OTHER NON-FINANCIAL ASSETS	**(61,182)**	-
INCREASE IN NET DEBT	**(183,624)**	(43,552)
OPENING NET DEBT	**(43,552)**	-
CLOSING NET DEBT	**$ (227,176)**	$ (43,552)

Statement of Cash Flows
March 31, 2007

	2007	2006 (Notes 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Annual surplus	**$ -**	$ -
Less items not affecting cash		
Amortization of deferred capital contribution (Note 7)	**(56,961)**	(14,804)
Amortization of capital assets	**56,961**	14,804
	-	-
USES		
Increase in accounts receivable	**(4,931)**	-
Increase in prepaid expenses	**(61,182)**	-
	(66,113)	-
SOURCES		
Increase in accounts payable and accrued liabilities	**576,671**	-
Increase in due to MOHLTC	**410,040**	28,370
Increase in due to MOHLTC - E-Health	**25,218**	-
Increase in due to the LHIN Shared Services Office	**53,241**	-
	1,065,170	28,370
INVESTING		
Acquisition of capital assets	**(179,403)**	(58,356)
FINANCING		
Increase in deferred capital contributions (Note 7)	**179,403**	58,356
NET INCREASE IN CASH	**999,057**	28,370
CASH, BEGINNING OF YEAR	**28,370**	-
CASH, END OF YEAR	**$ 1,027,427**	$ 28,370

Notes to the Financial Statements
March 31, 2007

1. DESCRIPTION OF BUSINESS

Formation and Status

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Champlain Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an annual Accountability Agreement for the 2007 fiscal year with the Ministry of Health and Long Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN Operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN is home to about 443,000 people, which encompass the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties.

2. SIGNIFICANT ACCOUNTING POLICIES

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of Accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and losses in the value of assets.

Notes to the Financial Statements
March 31, 2007

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

Government Transfer Payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred Contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. This amortization revenue recorded is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible Capital Assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized, on a straight line basis, over their estimated useful lives as follows:

Office equipment	5 years
Computer equipment	3 years
Leasehold improvements	Life of lease

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Notes to the Financial Statements
March 31, 2007

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Use of Estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $43,552 on the statement of financial position. On the statement of financial activities amortization of deferred capital contributions increased by $14,804 as did general and administrative expenses. On the statement of changes in net debt acquisition of tangible capital assets increased by $58,356 amortization of tangible capital assets increased by $14,804 and closing net debt increased by $43,552.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

As at March 31, 2006, the MOHLTC included accounts payable and accrued liabilities totaling $150,501 in its records on behalf of the LHIN. These expenses are included in amounts disclosed in Note 10 related to the prior period.

5. E-HEALTH

During fiscal 2007, the South East LHIN received funding in the amount of $104,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan. Unspent funds are repayable to the MOHLTC.

6. RELATED PARTY TRANSACTIONS

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs, typically on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end is recorded as a receivable (payable) to the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

Notes to the Financial Statements
March 31, 2007

7. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$ 43,552**	$ -
Capital contributions received during the year	**179,403**	58,356
Amortization for the year	**(56,961)**	(14,804)
Balance, end of year	**$ 165,994**	$ 43,552

8. CAPITAL ASSETS

	2007			2006
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Office equipment	**$ 49,129**	**$ 16,797**	**$ 32,332**	$ 27,885
Computer equipment	**71,776**	**31,597**	**40,179**	15,667
Leasehold improvements	**116,854**	**23,371**	**93,483**	-
	$ 237,759	**$ 71,765**	**$ 165,994**	$ 43,552

9. BUDGET FIGURES

The budget figures have been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

10. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes.

Salaries and benefits	$ 66,805
Accommodation/occupancy	1,133,960
Common services	42,126
Information technology	73,355
Other expenditures	305,523
	$ 1,621,769

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transition, amounts totalling $115,992 of prior period expenses were not accrued and these amounts were included in the March 31, 2007 Statement of Financial Activities of the LHIN.

Notes to the Financial Statements
March 31, 2007

10. GENERAL AND ADMINISTRATIVE EXPENSES (continued)

The Statement of Financial Activities' expenses are classified by object, as follows:

	2007	2006
Program based		
Salaries and benefits	$ 1,216,643	$ 210,086
Consulting and LHIN-based projects	379,513	-
	1,596,156	210,086
Mail, courier and telecommunications	40,230	497
Shared services	299,349	-
Board per diem	177,164	-
Office equipment and supplies	86,681	532
Public relations	92,780	-
Other	218,056	2,476
Amortization	56,961	14,804
Occupancy	218,157	-
	$ 2,785,534	$ 228,395

11. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 19 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2007 was $83,200 (2006 - $14,715) for current service costs and is included as an expense in the Statement of Financial Activities.

12. GUARANTEES

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. COMMITMENTS

The LHIN has commitments under various operating leases to 2010, including building and equipment leases. Lease renewals are likely. Minimum lease payments due in each of the next three years are as follows:

2008	$ 127,339
2009	126,635
2010	51,458
	$ 305,432

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 9, 2005 to March 31, 2006.

During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

Annual Remuneration for Board Members

The reporting period for board members' remuneration includes the 12 month period from April 01, 2006 to March 31, 2007; this includes nine board members in total during this period.

Per Diems $177,164

South East
Local Health Integration Network

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